

Birth Plan



NAME: PRONOUNS: AGE:

RACE/ETHNICITY: DUE DATE:

DOCTOR/MIDWIFE: BABY NAME:
LOCATION:

SETTING: hospital birth center home **I ALSO NEED:** transportation interpreter

BIRTH TYPE: vaginal cesarean VBAC water **INDUCTION DATE:**

HEALTH FACTORS:

ALLERGIES:

Birth Team

Name:

Relationship:

Role:



Medical Interventions/Induction

In case of C-section, I would like:

- one free arm clear drapes to stay awake

I consent to the following procedures:

- | | | |
|--|--|--|
| <input type="checkbox"/> Cervical checks | <input type="checkbox"/> Electronic fetal monitoring (continued or intermittent) | <input type="checkbox"/> Amniotomy (intentional breaking of water) |
| <input type="checkbox"/> Epidural | <input type="checkbox"/> Membrane sweep | <input type="checkbox"/> Cervix balloon |
| <input type="checkbox"/> Episiotomy | <input type="checkbox"/> Cervix ripening agents (pill, gel, or vaginal insert) | <input type="checkbox"/> IV Connection |
| <input type="checkbox"/> Pitocin | | |

Pain Management

If medically possible, I would prefer:

- | | | |
|---|--|--|
| <input type="checkbox"/> Breathing/Meditation | <input type="checkbox"/> Hydrotherapy | <input type="checkbox"/> Changing Positions: |
| <input type="checkbox"/> Massage | <input type="checkbox"/> IV Medication | <input type="checkbox"/> Lying on back |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Epidural | <input type="checkbox"/> Lying on side |
| <input type="checkbox"/> Visualization | <input type="checkbox"/> Vocalization (low moaning or grunts) | <input type="checkbox"/> Squatting |
| | | <input type="checkbox"/> Standing |
| | | <input type="checkbox"/> On all fours |

Comfort Measures

- | | |
|---|--|
| <input type="checkbox"/> Music played (I will provide) | <input type="checkbox"/> To walk/movement |
| <input type="checkbox"/> The lights dimmed | <input type="checkbox"/> To film and/or take pictures |
| <input type="checkbox"/> The room as quiet as possible | <input type="checkbox"/> Birthing/Peanut Ball |
| <input type="checkbox"/> As few interruptions as possible | <input type="checkbox"/> Stay hydrated with clear liquids and ice chips |
| <input type="checkbox"/> Birth affirmations | <input type="checkbox"/> To eat and drink as approved by my doctor |
| <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Only my own doctor and nurses in the room (no students, residents or interns) |

Newborn Procedures

- | | |
|--|--|
| <input type="checkbox"/> All procedures and medications are to be explained to me beforehand. I want my baby to be circumcised. | <input type="checkbox"/> If my baby has to be taken from me for medical treatment, I want my support person to go with them. |
| <input type="checkbox"/> Golden hour (1 hour of uninterrupted skin to skin contact) | <input type="checkbox"/> I want to keep my placenta for encapsulation or artwork. (A cooler must be provided by the family.) |
| <input type="checkbox"/> Newborn vaccines (vitamin K shot, eye-ointment) | <input type="checkbox"/> Cord Care: Cut/Delayed cord clamping Who will cut umbilical cord? _____ |
| <input type="checkbox"/> Infant Feeding: BF/ formula/ Donated Human milk | |

Additional Notes

